Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4202SNF	A. BUILDING _____ B. WING _____	C 09/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

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Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 7/29/09 and finalized on 9/4/09, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00022638 was unsubstantiated with unrelated deficiencies cited. (See Tag Z 300). Complaint #NV00022579 was substantiated with deficiencies cited. (See Tag Z 300). Complaint #NV00023010 was unsubstantiated with unrelated deficiencies cited. (See Tag 300). Complaint #NV00022560 was substantiated with no deficiencies cited. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000		
Z300 SS=G	NAC 449.74491 Prohibited practices 1. A facility for skilled nursing shall adopt and carry out written policies and procedures that prohibit:	Z300	**Preparation and/or execution of these Documents and Plan(s) of Correction does not constitute admission or agreement by the Provider, or the truth of the facts alleged or**	

RECEIVED
OCT 05 2009
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Kathleen Broderick — TITLE — (X6) DATE 10/5/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z300	Continued From page 1 a) The mistreatment and neglect of the patients in the facility; b) The verbal, sexual, physical and mental abuse of the patients in the facility; c) Corporal punishment and involuntary seclusion; and d) The misappropriation of the property of the patients in the facility. This Regulation is not met as evidenced by: Based on record review, policy review, and interview the facility failed to investigate a report of sexual abuse that occurred on 5/10/09 and, as a result, failed to develop corrective action in order to protect a second resident from sexual abuse. (Residents #2 and #3) Findings include: The facility's policy for Abuse Prohibition was reviewed and revealed: "B.1. Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator." The policy includes an investigation protocol and that the shift nurse "shall complete the Accident/Incident Tracking Log." Resident #1 was admitted to the facility on 7/5/05, with diagnoses including dementia with behavioral disturbance, and schizoaffective disorder. Resident #2 was admitted to the facility on 3/27/09, with diagnoses including dementia with behavioral disturbances, Alzheimer's Disease, muscle weakness, and gait abnormality. Resident #3 was admitted on 4/14/09, with	Z300	**conclusions set forth in the State of Deficiencies. These Documents and Plan(s) of Correction are prepared and/or executed solely because it is required by the provisions of Federal and State law.** **Let this Plan of Correction serve as the facilities credible allegation of compliance.** **Z300** **It is the policy of the Facility to prohibit mistreatment, neglect and abuse of residents.** **All residents have the potential of being affected by this policy.** **Residents #1,2,3, care plans had been updated.** **Staff In serviced on 7/23/7/30,8/20 2009 and will be re-in serviced on Oct. 7, 2009 on Abuse Prohibition,reporting,unknown injury, documentation and family notification.**	

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Z300	Continued From page 2 diagnoses including Alzheimer's Disease, cognitive deficits, muscle weakness, and gait abnormality. Review of the record revealed a document titled "Witness Statement Sheet" dated 5/10/09 at 10:15 AM. The document indicated that a certified nursing assistant (CNA) observed Resident #1 with "his (Resident #1) hand on hers (Resident #2) and started to rub her legs and continued to her private area." The "Witness Statement Sheet" indicated that the CNA had reported the observation to a nurse. The CNA was interviewed on 8/4/09 at 9:00 AM, and reported that she had completed the "Witness Statement Sheet" and did observe the sexual abuse taking place as she had reported in the statement. She stated that she had reported this to a nurse. She reported that she was "not sure" which nurse she had reported it to as it had "occurred in May of 2009." An LPN was interviewed on 7/30/09 at 10:30 AM, and reported that she "worked the evening shift and heard second hand that Resident #1 had abused Resident #2." She stated that the procedure for reporting incidents to administration was that the witness statement was disbursed to the director of nursing (DON), the assistant administrator and the administrator. She reported that the incident should have been recorded in the medical record. She reported that she had no knowledge that the procedure was carried out. Review of the clinical records for Resident #1 and #2 failed to reveal documentation of the incident. Review of Resident #1's record failed to reveal evidence of a care plan after the 5/10/09 incident	Z300	**All events are to be reported to the Administrator in person by staff or by phone if after-hours. Administrator will be responsible for notifying the Licensing Bureau within (24) hours and to initiate a through investigation.** **DON/Designee to maintain the I/A Log and will update the care plan to prevent further incidents and to meet the needs of the resident/s.** **During rounds the DON/Designee will ensure compliance with the updated Care Plan. Special events will be reviewed wkly in the IDT meeting and monthly in the CQI meeting for review and recommendations if needed.** **DON/Designee will monitor all reported events made to the Licensing Bureau times (4) months to ensure care plan is updated/family / Dr/notified and will report outcome to Administrator for review.**	10/17/09

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Z300	Continued From page 3 to protect other residents from inappropriate sexual touching. The administrator was interviewed on 7/29/09 at 12:45 PM, and reported that she had no knowledge of the allegation. She stated that she had not been working at the facility at the time of the alleged incident. Resident #2's legal guardian was interviewed on 7/30/09 at 1:10 PM, and stated that she had not been informed of the incident and was "shocked" to learn of the incident during our conversation. Record review revealed that Resident #1 had sexually abused Resident #3 on 7/16/09. A summary of events related to the allegation of sexual abuse on 7/16/09, read: "It was reported that approximately 3:45 PM, per the CNA that she came upon Resident #1 standing very close to Resident #3 which was out of character for Resident #1. She noted at that time Resident #1 had his hand down the front of Resident 3's pants. Resident #1 removed his hand immediately and went over to the television room." Severity: 3 Scope: 2	Z300		
Z301 SS=G	NAC 449.74491 Prohibited practices 2. A facility for skilled nursing shall adopt procedures which ensure that all alleged violations of the policies adopted pursuant to subsection 1 and injuries to patients of unknown origin are reported immediately to the administrator of the facility, to the bureau and to other officials in accordance with state law, and are thoroughly investigated. The procedures must ensure that further violations are prevented while	Z301	**Z301** **It is the policy of the Facility to prohibit mistreatment neglect and abuse of residents.** **All residents have the potential of being affected by this policy.**	

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Z301	Continued From page 4 the investigation is being conducted. This Regulation is not met as evidenced by: Based on record review, interview, and policy review the facility failed to investigate and report to the Bureau an allegation of sexual abuse for 1 of 8 residents (Resident #2) and and failed to investigate and report to the Bureau bruising of unknown origin for 1 of 8 residents (Resident #7). Findings include: Resident #1 was admitted to the facility on 7/5/05, with diagnoses including dementia with behavioral disturbance, and schizoaffective disorder. Resident #2 was admitted to the facility on 3/27/09, with diagnoses including dementia with behavioral disturbances, Alzheimer's Disease, muscle weakness, and gait abnormality. Resident #3 was admitted on 4/14/09, with diagnoses including Alzheimer's Disease, cognitive deficits, muscle weakness, and gait abnormality. Review of the record revealed a document titled "Witness Statement Sheet" dated 5/10/09 at 10:15 AM. The document indicated that a certified nursing assistant (CNA) observed Resident #1 with "his (Resident #1) hand on hers (Resident #2) and started to rub her legs and continued to her private area." The "Witness Statement Sheet" indicated that the CNA had reported the observation to a nurse. The CNA was interviewed on 8/4/09 at 9:00 AM, and reported that she had completed the	Z301	**Residents #1,2,3, Care Plans had been updated.** **Staff in serviced on 7/23,7/30,8/20 2009 and will be re-in serviced on 10/7/09 on Abuse Prohibition,reporting unknown injury,documentation and family notification.** **All events are to be reported to the Administrator in person by staff or by phone if after-hours. Administrator will be responsible for notifying the Licensing Bureau within (24) hours and to initiate a through investigation.** **DON/Designee to maintain the I/A Log and will update the care plan to prevent further incidents and to meet the needs of the resident/s.** **During rounds the DON/Designee will ensure compliance with the updated** **Care Plan Special events will be reviewed wkly in the IDT meeting and monthly in the CQI meeting for review and recommendations if needed.**	10/7/09

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Z301	Continued From page 5 "Witness Statement Sheet" and did observe the sexual abuse taking place as she had reported in the statement. She stated that she had reported this to a nurse. She reported that she was "not sure" which nurse she had reported it to as it had "occurred in May of 2009." Review of the clinical record failed to reveal documentation of the incident. The facility failed to provide evidence of an investigation or that the event was reported to the Bureau. The administrator was interviewed on 7/29/09 at 12:45 PM, and reported that she had no knowledge of the allegation. She stated that she had not been working at the facility at the time of the alleged incident. Resident #7 was admitted to the facility on 8/8/06 with diagnoses that included pressure ulcers and dementia. On 1/7/08 at 1:32 AM, a CNA alerted the RN to a darkened area around the Resident #7's anus. It was documented as looking like bruising under the skin, no open areas were noted. At 9:20 AM the resident was examined by the director of nursing (DON), a second RN, and two CNAs. The nurse noted, "there is a dark blue or black area fanning out from anus. Area around anus pink. No lacerations noted. Will have nurse practitioner see her tonight." At 6:35 PM the advanced practitioner of nursing (APN) examined the resident and documented a "deep tissue injury to rectal area" and recommended pressure relief to the rectum. The resident was followed daily with no complaints of pain; the bruising was noted as healing. After the bruising in the rectal area was noted, the resident continued to have regular bowel movements.	Z301	**DON/Designee will monitor all reported events made tot the Licensing Bureau times (4) months to ensure care plan is updated/family/ Dr. notified and will report outcome to Administrator for review.**	

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Z301	Continued From page 6 The facility's policy for Abuse Prohibition was reviewed and revealed: "B.1. Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator." The policy includes and investigation protocol and that the shift nurse "shall complete the Accident/Incident Tracking Log." The facility uses an electronic reporting system and an event would have been completed electronically for the bruising of unknown origin. Review of the facility's event log from 2007 through 2009 failed to reveal documentation of the bruising found on Resident #7 or the 5/10/09 incident involving Residents #1 and #2. The 5/10/09 incident or the bruising of unknown origin were not reported to the Bureau as required. There was no evidence that an investigation had been done. Severity: 3 Scope: 1	Z301		
Z310 SS=D	NAC449.74493 Notification of Changes or Condition 1. A facility for skilled nursing shall immediately notify a patient, the patient's legal representative or an interested member of the patient's family, if known, and, if appropriate, the patient's physician, when: (a) The patient has been injured in an accident and may require treatment from a physician; (b) The patient's physical, mental or psychosocial health has deteriorated and resulted in medical complications or is threatening the patient's life; (c) There is a need to discontinue the current	Z310	**Z310** **It is the policy of the Facility to inform family members/representative and Physician of any change in residents condition.** **All residents have the potential to be affected by this policy.**	

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Z310	Continued From page 7 treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment; (d) The patient will be transferred or discharged from the facility; (e) The patient will be assigned to another room or assigned a new roommate; or (f) There is any change in federal or state law that affects the rights of the patient. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to notify the responsible party of an allegation of sexual abuse for 1 of 8 residents. (Resident #2) Findings include: Resident #1 was admitted to the facility on 7/5/05, with diagnoses including dementia with behavioral disturbance, and schizoaffective disorder. Resident #2 was admitted to the facility on 3/27/09, with diagnoses including dementia with behavioral disturbances, Alzheimer's Disease, muscle weakness, and gait abnormality. Review of the record revealed a document titled "Witness Statement Sheet" dated 5/10/09 at 10:15 AM. The document indicated that a certified nursing assistant (CNA) observed Resident #1 with "his (Resident #1) hand on hers (Resident #2) and started to rub her legs and continued to her private area." The "Witness Statement Sheet" indicated that the CNA had reported the observation to a nurse. Resident #2's legal guardian was interviewed on 7/30/09 at 1:10 PM, and stated that she had not been informed of the incident and was "shocked"	Z310	**Residents #1,2, had been notified of incidents.** **Staff in serviced on 7/23/30/8/30 2009 and will be re-in serviced on 10/07/09 on Abuse Prohibition, reporting, unknown injury, documentation and family notification.** **DON/Designee will monitor documentation on State Reported events to ensure compliance of notification of family/Dr. notification and care plan update for (4) months.** **DON/Designee will report to the IDT meeting wkly and CQI Committee monthly for review and recommendation if needed.**	10/17/09

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Z310	Continued From page 8 to learn of the incident during our conversation. Severity: 2 Scope: 1	Z310		